

Benefits Administration Training Team

Understanding EOB Terminology and Searching Vendor Websites

Basic Insurance Definitions

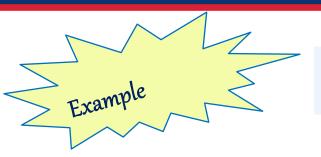
Allowable Charge

(Also referred to as the *Allowed Amount, Approved Charge* or *Maximum Allowable*)

This is the dollar amount typically considered payment-in-full by an insurance company and an associated network of healthcare providers. The Allowable Charge is typically a discounted rate rather than the actual charge.



Allowed Amount Example



Scenario: You visit the doctor for an earache. The total charge for the visit comes to \$100.

- ▶ If the doctor is an in-network provider, he or she is required to accept \$80 (negotiated fee) as paymentin-full for the visit. This is the *Allowable Charge*. The remaining \$20 is considered provider write-off, for which you cannot be billed.
- After you pay your co-payment/co-insurance, the health insurance plan will pay the remaining balance.

Doctor Visit for Earache				
Cost of visit	\$100			
Negotiated Fee (Allowable Charge)	\$80			
Doctor Write Off	\$20			

NOTE: If the doctor is an out-of-network provider then you will be held responsible for the amount your health insurance company will not pay, up to the full charge of \$100.



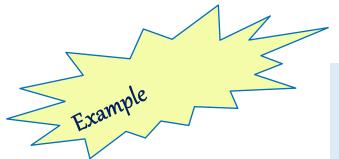
Basic Definitions - Continued

Deductible

The amount you owe for eligible healthcare services before your health insurance plan begins to pay.



Deductible Example



Scenario: If your deductible is \$1000, your plan won't pay anything until you've met your deductible for covered healthcare services.

Cost of Services	\$1350
Member Deductible Paid	\$1000
Amount covered for eligible healthcare services	\$350

NOTE: The deductible may not apply to all services



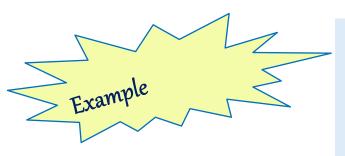
Basic Definitions - Continued

Co-insurance

The cost a member pays for a covered healthcare service. This cost is calculated as a percent of the allowed amount for the service (i.e. 80/20%). The member pays co-insurance plus any deductibles owed.



Co-insurance Example



Scenario: If the health insurance plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance plan pays the rest of the allowed amount.

Office Visit Allowed Amount	\$100
Member pays 20% after deductible is met	\$20
Health Insurance Plan pays 80%	\$80



Basic Definitions - Continued

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.



Basic Definitions - Continued

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you.

You'll pay more to see a non-preferred provider. A non-preferred provider would be considered "out of network."



Understanding Costs

Jane's Plan Deductible: \$1,500 Co-insurance: 20% Out-of-Pocket Limit: \$5,000

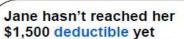
January 1st
Beginning of Coverage
Period

December 31st End of Coverage Period



Jane pays 100%

Her plan pays 0%



Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0







Jane reaches her \$1,500 deductible, co-insurance begins

Jane pays

20%

Her plan pays

80%

Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75 Jane pays: 20% of \$75 = \$15 Her plan pays: 80% of \$75 = \$60











Jane pays Her plan pays 100%

Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

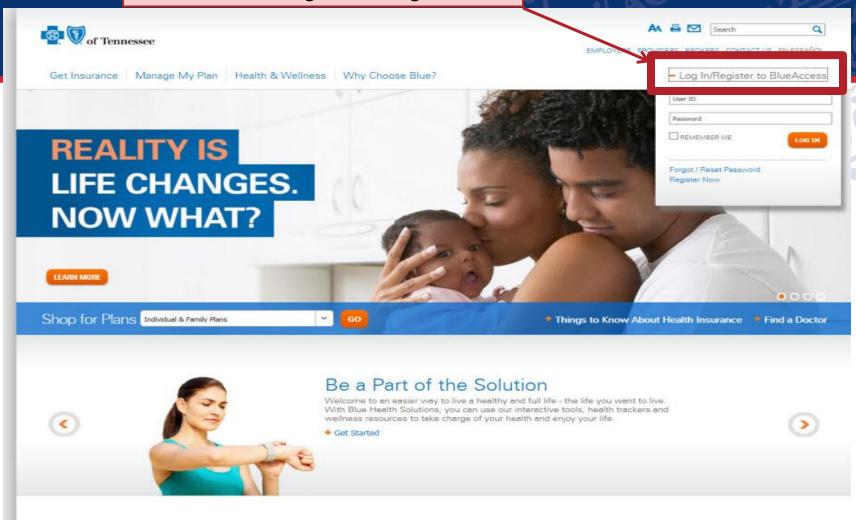
Office visit costs: \$200 Jane pays: \$0 Her plan pays: \$200





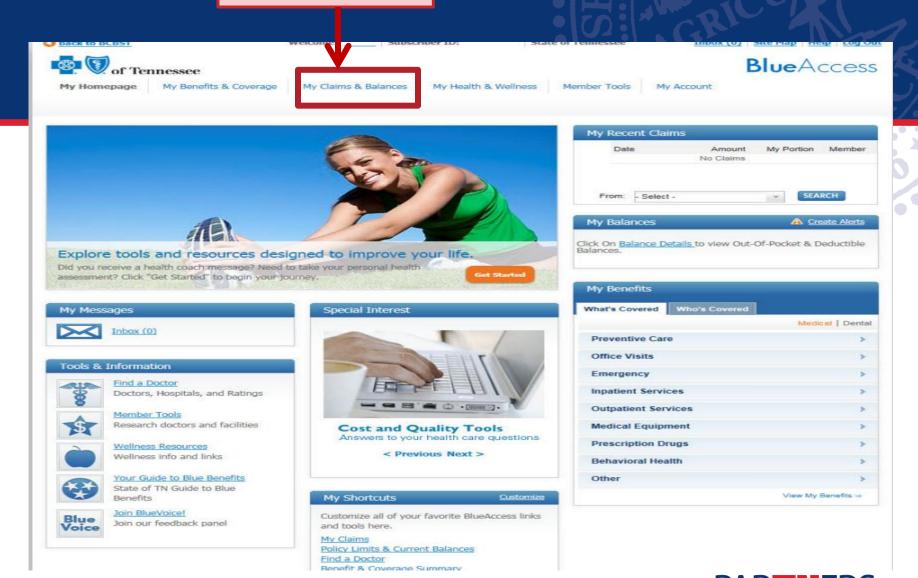
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My Claims & Balances

View your medical, dental and prescription drug claims history, compare your copayments against to all charges and learn the status of your claims. Find out how much your health plan saves you.

My Annual Statement



Review your annual health care expenses in a guick. easy summary.

Printable EOBs



Print and view Explanation of Benefits (EOB) associated with your processed claims.

My Claims



Check to see if your claims have been finalized. Browse by member's name, a date of service range and/or claim type (facility or physician). View up to 18 months of claim payment details.

My Balances



Find out if you've met your deductibles, out-ofpocket limits, service limits and lifetime limits for your medical, dental and vision coverages.

My FSA/HRA



View your accumulated and remaining Healthcare Reimbursement Account (HRA) and Flexible Spending Account balances.

My Preauthorizations



Learn about the covered services that require a referral or pre-authorization.

We're Here to Help Contact Us

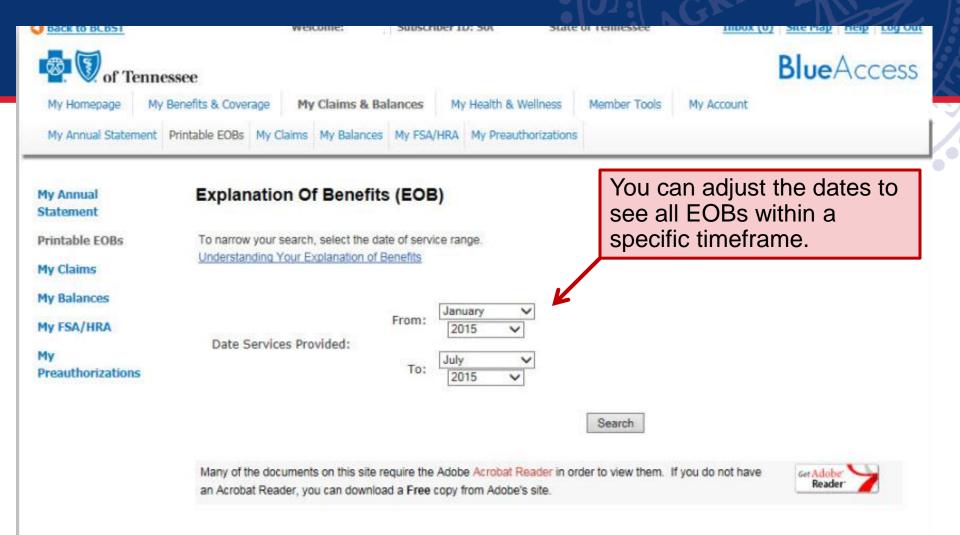
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Preauthorizations

Explanation Of Benefits (EOB)

Click one of the download links below to view the EOB. View another date range.

Show 10 v entries

Patient Name	Date Services Provided	Provider Name	Total Charge Submitted	Claim #	Medical/Dental	EOB Date	Actio
	01/27/2015	LEWIS, ROZMOND J.	328.94		м	02/05/2015	7
	04/22/2015	PATHGROUP LABS LLC	185.16		м	05/07/2015	
	04/22/2015	PATHGROUP LABS LLC	223.17		м	05/07/2015	
	04/22/2015	LEWIS, ROZMOND J.	176.46		м	05/07/2015	

Showing 1 to 4 of 4 entries

Many of the documents on this site require the Adobe Acrobat Reader in order to view them. If you do not have an Acrobat Reader, you can download a Free copy from Adobe's site.





Claim Number: EXTMM Received 01/29/2015 Group Number: 80860

S00 Identification No:

Patient Name:

Date Services Provided: 01/27/2015

Provider Name: LEWIS, ROZMOND J.

SUMMARY

Total Charge Submitted 328.94

Total Benefits Provided/Network Savings 303.94

Other Insurance Benefits .00

Amount You Owed Provider (Contact your provider if you receive a bill for

more than your EOB indicates that you owe.)

If you have questions about this statement, please call

25.00

1-800-558-6213

or visit Member Self-Service at our web site at www.bcbst.com to view this information and more.

Chattanooga 8:00 A.M.-5:15 P.M. (ET) Memphis 7:00 A.M.-4:15 P.M. (CT) Monday - Friday

THIS IS NOT A BILL

ITEMIZATION OF CHARGES

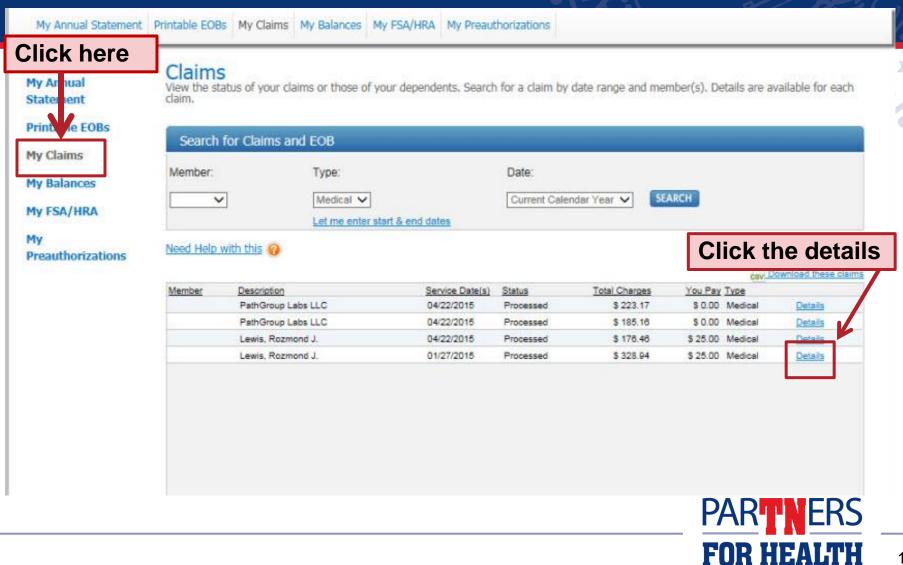
Date of Service		Services ncluded	Submitted Charges	Network Savings	Coinsurance if Applicable		Non- Covered	Notes	Paid Provider
01/27/15	Medical S	ervices	272.92	138.54		25.00			109.38
01/27/15	Medical S	ervices	46.02	24.96					21.06
01/27/15	Medical S	ervices	10.00	9.84					. 16
	TOTAL		328.94	173.34		25.00		Z3S	130.60

Z3S - You have used a network "S" provider.

Your **Allowed Amount** is calculated by subtracting the **Network Savings** from the **Submitted** Charges. This amount would be equal to the amount the Provider Paid and the Copay.



Another way to see your Allowed Amount would be to look at the claim.



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Claim Details Understanding Your Claim @

Member Description Lewis, Rozmond J. Service Date(s) 01/27/2015 Claim Received 01/29/2015

Status Processed Network Blue Network S Claim Processed 02/05/2015

Download EOB for this claim. | Search all EOBs. | Review Provider

Claim EXTMM:

Type Medical

Claim Amo	ount	BCBST and Oth	er Pay	You pa	зу
Total charges	\$328.94	BCBST pays you	\$0.00	Co-pay	\$25.00
Network saving	\$173.34	BCBST pays provider	\$130.60	Deductible	\$0.00
		Other insurance pays	\$0.00	Coinsurance	\$0.00
		HRA pays	\$0.00	Not covered	\$0.00
Allowed amount	\$155.60	Covered amount	\$155.60	What you pay	\$27.00

Services

Service	Submitted Charges	Allowed Amount	BCBST Pays Provider
Injections PSV	\$10.00	\$0.16	\$0.16
Injections PSV	\$46.02	\$21.06	\$21.06
Office - Practitioner Visit Primary Care *PSV	\$272.92	\$134.38	\$109.38

*Remarks

PSV This charge exceeds the maximum allowable under this member's coverage. Medical Balances

As of 07/28/2015

Amount Remaining

Network

Out

Deductible \$450.00

\$800.00

View Balance Details ->

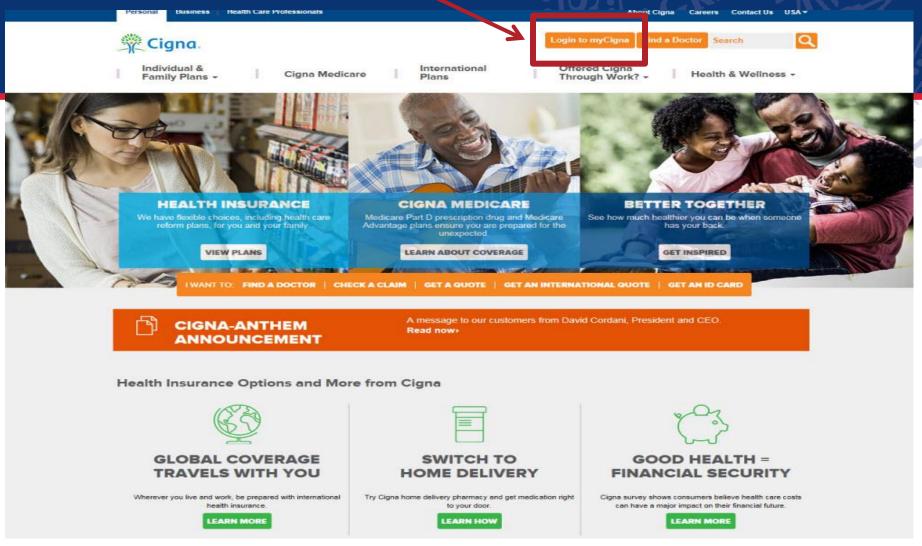
Your **Allowed Amount** for all services would be the amount that you would pay under the CDHP.





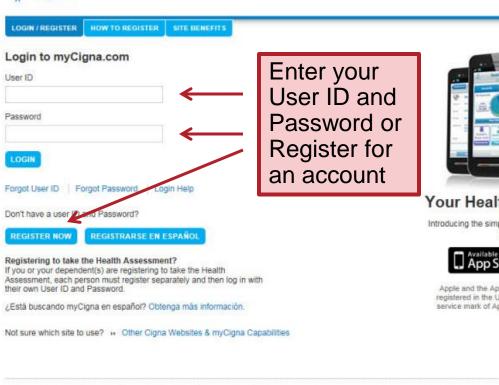
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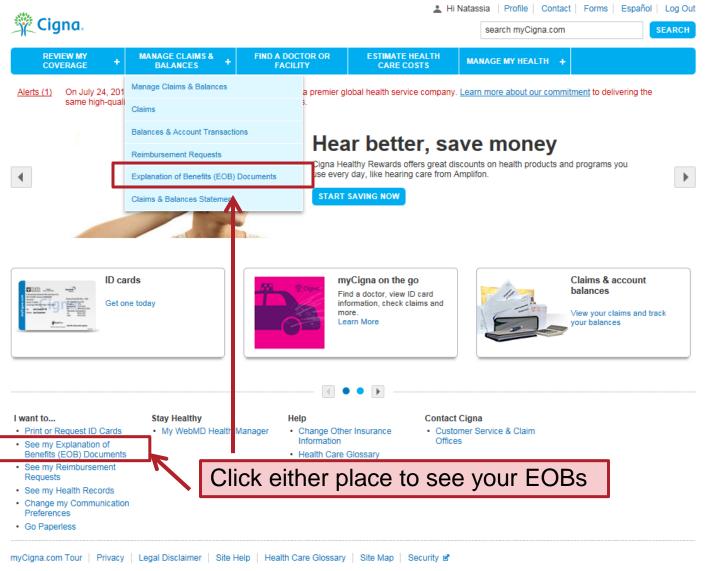




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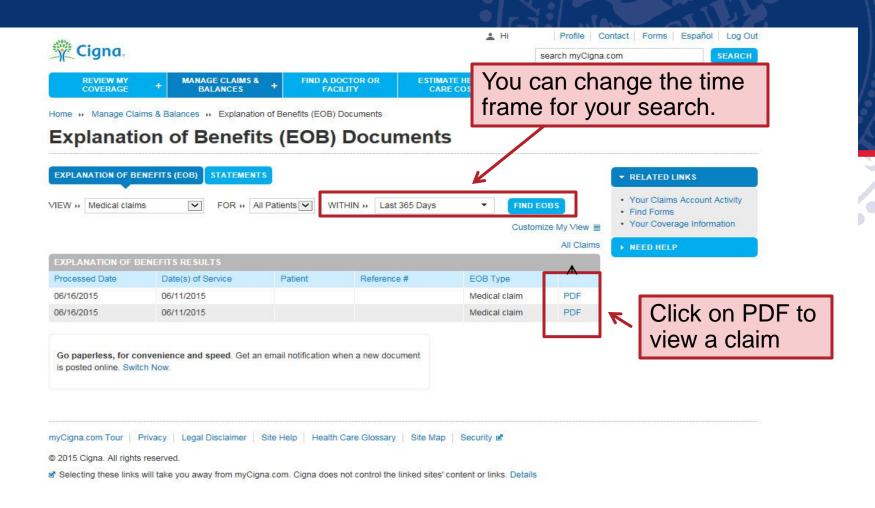






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Feedback





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STATE OF TENNESSEE-MIDDLE LP / 3337280

Explanation of benefits

for a claim received for

, Reference #

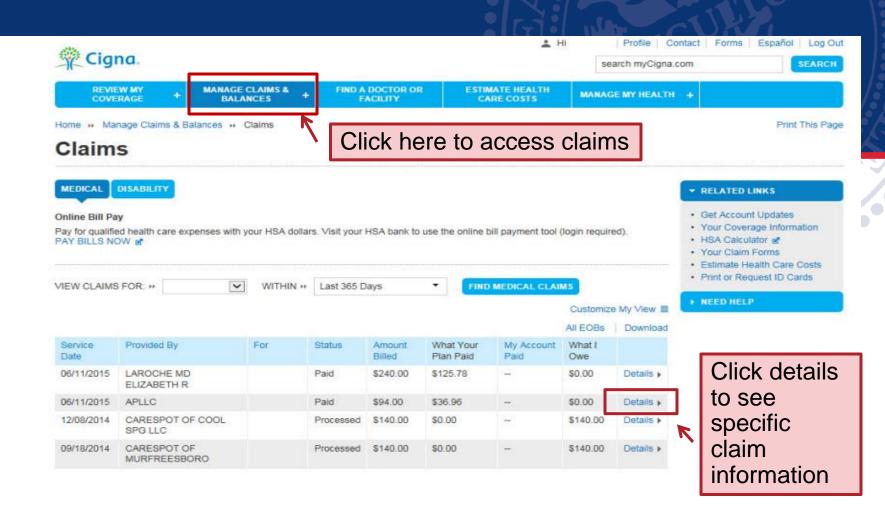
Summary of a claim for services on June 11, 2015

for services provided by APLLC

The Allowed Amount is
calculated by subtracting the
Discount from the Amount
Billed. It is equal to what your
plan paid in this scenario.

-		plan pala in the econome.
Amount Billed	\$94.00	This was the amount that was billed for your visit on 06/11/2015.
Discount	\$57.04	You saved \$57.04. CIGNA negotiates discounts with health care professionals and facilities to help you save money.
What your plan paid	\$36.96	Your plan paid \$36.96 to APLLC.
What I owe	\$0.00	This is the amount you owe after your discount, your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid since care was received may reduce the amount you owe.
You saved	100%	You saved \$94.00 (or 100%) off the total amount billed. This is a total of your discount and what your plan paid. To maximize your savings, visit www.myClGNA.com or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.

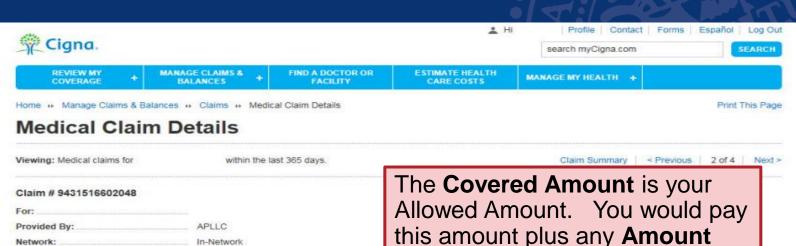




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Network: In-Network: In-Networ

Service Date & Discount Amount Not Covered What Your Plan Amount Copay / Coinsurance What I See Billed Covered Amount Deductible Paid. Owe Notes Type 06/11/2015 • \$94.00 \$57.04 \$0.00 \$36.96 \$0.00 100% = \$36.96 \$0.00 0248 LABORATORY TOTALS \$94.00 \$0.00 \$36.96 \$0.00 \$36,96 \$0.00 \$0.00 \$57.04

The claim information provided reflects our data at the time your claim was processed. Due to ongoing claims processing activities, such as the payment of additional claims or an adjustment to this claim, the information may not show the final customer coinsurance amount, if one applies to your plan.

NOTES

0248-\$57.04 - CUSTOMER: THANK YOU FOR USING CIGNA'S OPEN ACCESS PLUS NETWORK. THE DISCOUNT SHOWN IS HOW MUCH YOU SAVED. YOU DON'T NEED TO PAY THAT AMOUNT, IF YOU ALREADY PAID YOUR HEALTH CARE PROFESSIONAL MORE THAN THE "WHAT I OWE" AMOUNT, PLEASE ASK FOR A REFUND, HEALTH CARE PROFESSIONAL: YOUR CIGNA AGREEMENT DOES NOT ALLOW YOU TO BILL THE PATIENT FOR THE DIFFERENCE. IF YOU ARE IN INDIANA, CALIFORNIA OR TENNESSEE, PLEASE CONTACT CIGNA CUSTOMER SERVICE ALD 1.800.88CIGNA (882.4462) FOR INFORMATION ON YOUR DISCOUNTED RATE.

Claim Summary | < Previous | 2 of 4 | Next >



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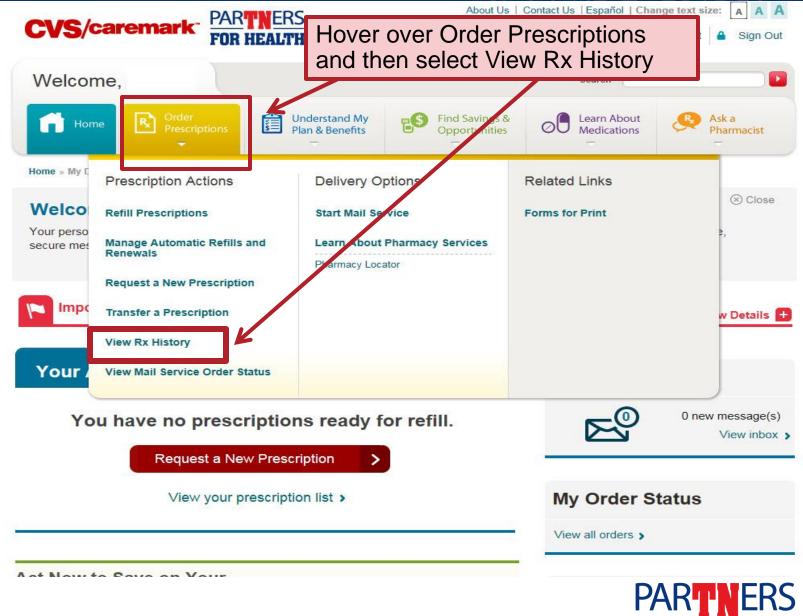
and Android apps.

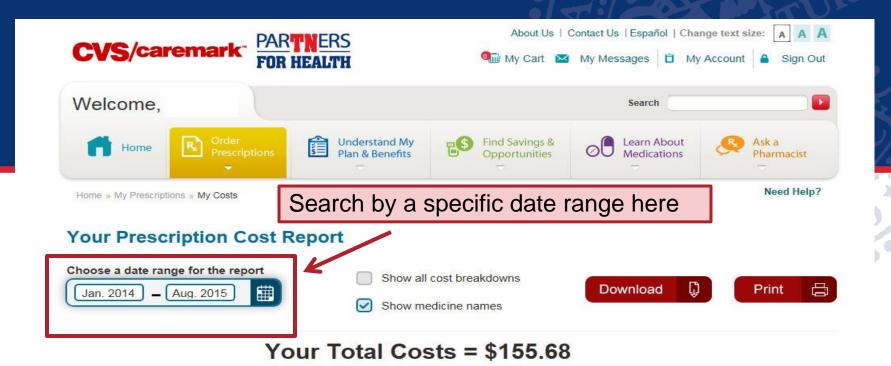
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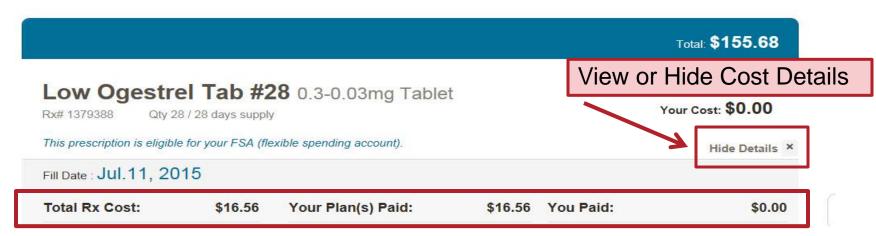
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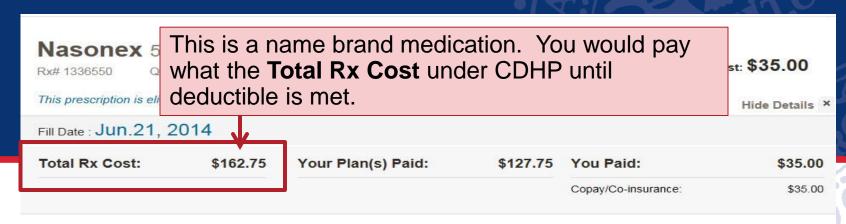






This is a medication that would still be covered at 100%





Methylprednisolone 4mg Tab Ds Pk

Rx# 1333776 Qty 21 / 6 days supply

This prescription is eligible for your FSA (flex

Fill Date: Jun. 10, 2014

This is a generic medication. You would still pay the Total Rx Cost for this medication until deductible is met.

Total Rx Cost: \$4.52 Your Plan(s) Paid: \$0.00 You Paid: \$4.52 Copay/Co-insurance: \$4.52

Epipen 2-Pak 0.3mg Auto Injet

Rx# 1316526 Qty 2 / 2 days supply

This prescription is eligible for your FSA (flexible spending account).

Fill Date: Mar. 30, 2014

Total Rx Cost: \$311.24

Your Plan(s) Paid:

\$276.24

You Paid:

\$35.00

Hide Details X

Copay/Co-insurance:

\$35.00

This is a name brand medication. You would pay what the **Total Rx Cost** under CDHP until deductible is met.



Your Cost: \$35.00

Your Cost: \$4.52



Questions?